

**AMENDMENT IN THE NATURE OF A SUBSTITUTE
TO H.R. 4507
OFFERED BY MR. GOOD OF VIRGINIA**

Strike all after the enacting clause and insert the following:

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Transparency in Cov-
3 erage Act”.

4 **SEC. 2. PROMOTING GROUP HEALTH PLAN AND GROUP**
5 **HEALTH INSURANCE COVERAGE PRICE**
6 **TRANSPARENCY.**

7 (a) IN GENERAL.—

8 (1) ERISA.—

9 (A) IN GENERAL.—Section 719 of the Em-
10 ployee Retirement Income Security Act of 1974
11 (29 U.S.C. 1185h) is amended to read as fol-
12 lows:

13 **“SEC. 719. PRICE TRANSPARENCY REQUIREMENTS.**

14 “(a) IN GENERAL.—A group health plan, and a
15 health insurance issuer offering group health insurance
16 coverage, shall make available to the public accurate and
17 timely disclosures of the following information:

18 “(1) Claims payment policies and practices.

1 “(2) Periodic financial disclosures.

2 “(3) Data on enrollment.

3 “(4) Data on disenrollment.

4 “(5) Data on the number of claims that are de-
5 nied.

6 “(6) Data on rating practices.

7 “(7) Information on cost-sharing and payments
8 with respect to any out-of-network coverage (or with
9 respect to any item and service furnished under such
10 a plan or such group health insurance coverage that
11 does not use a network of providers).

12 “(8) Information on participant and beneficiary
13 rights under this part.

14 “(9) Rate and payment information described
15 in subsection (d).

16 “(10) Other information as determined appro-
17 priate by the Secretary.

18 Rate and payment information described in paragraph (9)
19 shall be made available to the public not later than Janu-
20 ary 10, 2025, and not later than the tenth day of every
21 month thereafter, in the manner described in subsection
22 (d)(2)(A), and, beginning on January 1, 2027, in real-time
23 through an application program interface (or successor
24 technology) described in subsection (d)(2)(B).

1 “(b) USE OF PLAIN LANGUAGE.—The information
2 required to be submitted under subsection (a) shall be pro-
3 vided in plain language. The term ‘plain language’ means
4 language that the intended audience, including individuals
5 with limited English proficiency, can readily understand
6 and use because that language is clear, concise, well-orga-
7 nized, accurately describes the information, and follows
8 other best practices of plain language writing. The Sec-
9 retary, jointly with the Secretary of Health and Human
10 Services and the Secretary of Labor, shall develop and
11 issue standards for plain language writing for purposes
12 of this section and shall develop a standardized reporting
13 template and standardized definitions of terms to allow
14 for comparison across group health plans and health in-
15 surance coverage.

16 “(c) COST SHARING TRANSPARENCY.—

17 “(1) IN GENERAL.—A group health plan, and a
18 health insurance issuer offering group health insur-
19 ance coverage, shall, upon request of a participant
20 or beneficiary and in a timely manner, provide to the
21 participant or beneficiary a statement of the amount
22 of cost-sharing (including deductibles, copayments,
23 and coinsurance) under the participant’s or bene-
24 ficiary’s plan or coverage that the participant or
25 beneficiary would be responsible for paying with re-

1 spect to the furnishing of a specific item or service
2 by a provider. At a minimum, such information shall
3 include the information specified in paragraph (2)
4 and shall be made available at no cost to the partici-
5 pant or beneficiary through a self-service tool that
6 meets the requirements of paragraph (3) or through
7 a paper or phone disclosure, at the option of the
8 participant or beneficiary, that meets such require-
9 ments as the Secretary may specify.

10 “(2) SPECIFIED INFORMATION.—For purposes
11 of paragraph (1), the information specified in this
12 paragraph is, with respect to an item or service for
13 which benefits are available under a group health
14 plan or group health insurance coverage (as applica-
15 ble) furnished by a health care provider to a partici-
16 pant or beneficiary of such plan or coverage, the fol-
17 lowing:

18 “(A) If such provider is a participating
19 provider with respect to such item or service,
20 the in-network rate (as defined in subsection
21 (f)) for such item or service and for any other
22 item or service that is inherent in the fur-
23 nishing of the item or service that is the subject
24 of such request.

1 “(B) If such provider is not a participating
2 provider, the allowed amount, percentage of
3 billed charges, or other rate that such plan or
4 coverage will recognize as payment for such
5 item or service, along with a notice that such
6 individual may be liable for additional charges
7 billed by such provider.

8 “(C) The estimated amount of cost sharing
9 (including deductibles, copayments, and coin-
10 surance) that the participant or beneficiary will
11 incur for such item or service (which, in the
12 case such item or service is to be furnished by
13 a provider described in subparagraph (B), shall
14 be calculated using the amount or rate de-
15 scribed in such subparagraph (or, in the case
16 such plan or issuer uses a percentage of billed
17 charges to determined the amount of payment
18 for such provider, using a reasonable estimate
19 of such percentage of such charges)).

20 “(D) The amount the participant or bene-
21 ficiary has already accumulated with respect to
22 any deductible or out of pocket maximum under
23 the plan or coverage (broken down, in the case
24 separate deductibles or maximums apply to sep-
25 arate participants and beneficiaries enrolled in

1 the plan or coverage, by such separate
2 deductibles or maximums, in addition to any
3 cumulative deductible or maximum).

4 “(E) Any shared savings or other benefit
5 available to the participant or beneficiary with
6 respect to such item or service.

7 “(F) In the case such plan or coverage im-
8 poses any frequency or volume limitations with
9 respect to such item or service (excluding med-
10 ical necessity determinations), the amount that
11 such participant or beneficiary has accrued to-
12 wards such limitation with respect to such item
13 or service.

14 “(G) Any prior authorization, concurrent
15 review, step therapy, fail first, or similar re-
16 quirements applicable to coverage of such item
17 or service under such plan or group health in-
18 surance coverage.

19 “(3) SELF-SERVICE TOOL.—For purposes of
20 paragraph (1), a self-service tool established by a
21 group health plan or health insurance issuer offering
22 group health insurance coverage meets the require-
23 ments of this paragraph if such tool—

1 “(A) is based on an Internet website, mo-
2 bile application, or other platform determined
3 appropriate by the Secretary;

4 “(B) provides for real-time responses to re-
5 quests described in paragraph (1);

6 “(C) is updated in a manner such that in-
7 formation provided through such tool is accu-
8 rate at the time such request is made;

9 “(D) allows such a request to be made
10 with respect to an item or service furnished
11 by—

12 “(i) a specific provider that is a par-
13 ticipating provider with respect to such
14 item or service;

15 “(ii) all providers that are partici-
16 pating providers with respect to such plan
17 and such item or service for purposes of
18 facilitating price comparisons; or

19 “(iii) a provider that is not described
20 in clause (ii); and

21 “(E) provides that such a request may be
22 made with respect to an item or service through
23 use of the billing code for such item or service
24 or through use of a descriptive term for such
25 item or service.

1 The Secretary may require such tool, as a condition
2 of complying with subparagraph (E), to link multiple
3 billing codes to a single descriptive term if the Sec-
4 retary determines that the billing codes to be so
5 linked correspond to items and services.

6 “(4) PROVIDER TOOL.—A group health plan,
7 and a health insurance issuer offering group health
8 insurance coverage, shall permit providers to learn
9 the amount of cost-sharing (including deductibles,
10 copayments, and coinsurance) that would apply
11 under an individual’s plan or coverage that the indi-
12 vidual would be responsible for paying with respect
13 to the furnishing of a specific item or service by an-
14 other provider in a timely manner upon the request
15 of the provider and with the consent of such indi-
16 vidual in the same manner and to the same extent
17 as if such request has been made by such individual.
18 As part of any tool used to facilitate such requests
19 from a provider, such plan or issuer offering health
20 insurance coverage may include functionality that—

21 “(A) allows providers to submit the notifi-
22 cations to such plan or coverage required under
23 section 2799B–6 of the Public Health Service
24 Act; and

1 “(B) provides for notifications required
2 under section 716(f) to such an individual.

3 “(d) RATE AND PAYMENT INFORMATION.—

4 “(1) IN GENERAL.—For purposes of subsection
5 (a)(9), the rate and payment information described
6 in this subsection is, with respect to a group health
7 plan or group health insurance coverage (as applica-
8 ble), the following:

9 “(A) With respect to each item or service
10 (other than a drug) for which benefits are avail-
11 able under such plan or coverage, the in-net-
12 work rate (in a dollar amount) in effect as of
13 the first day of the plan year during which such
14 information is submitted with each provider
15 (identified by national provider identifier) that
16 is a participating provider with respect to such
17 item or service (or, in the case such rate is not
18 available in a dollar amount, such formulae,
19 pricing methodologies, or other information
20 used to calculate such rate).

21 “(B) With respect to each dosage form and
22 indication of each drug (identified by national
23 drug code) for which benefits are available
24 under such plan or coverage—

1 “(i) the in-network rate (in a dollar
2 amount) in effect as of the first day of the
3 plan year during which such information is
4 submitted with each provider (identified by
5 national provider identifier) that is a par-
6 ticipating provider with respect to such
7 drug (or, in the case such rate is not avail-
8 able in a dollar amount, such formulae,
9 pricing methodologies, or other information
10 used to calculate such rate); and

11 “(ii) the average amount paid by such
12 plan (net of rebates, discounts, and price
13 concessions) for such drug dispensed or
14 administered during the 90-day period be-
15 ginning 180 days before such date of sub-
16 mission to each provider that was a par-
17 ticipating provider with respect to such
18 drug, broken down by each such provider
19 (identified by national provider identifier),
20 other than such an amount paid to a pro-
21 vider that, during such period, submitted
22 fewer than 20 claims for such drug to such
23 plan or coverage.

24 “(C) With respect to each item or service
25 for which benefits are available under such plan

1 or coverage, the amount billed, and the amount
2 allowed by the plan or coverage, for each such
3 item or service furnished during the 90-day pe-
4 riod specified in subparagraph (B) by a pro-
5 vider that was not a participating provider with
6 respect to such item or service, broken down by
7 each such provider (identified by national pro-
8 vider identifier), other than items and services
9 with respect to which fewer than 20 claims for
10 such item or service were submitted to such
11 plan or coverage during such period.

12 Such rate and payment information shall be made
13 available with respect to each individual item or
14 service, regardless of whether such item or service is
15 paid for as part of a bundled payment, episode of
16 care, value-based payment arrangement, or other-
17 wise.

18 “(2) MANNER OF PUBLICATION.—

19 “(A) IN GENERAL.—Rate and payment in-
20 formation required to be made available under
21 subsection (a)(9) shall be so made available in
22 dollar amounts through 3 separate machine-
23 readable files corresponding to the information
24 described in each of subparagraphs (A) through
25 (C) of paragraph (1) that meet such require-

1 ments as specified by the Secretary not later
2 than 180 days after the date of the enactment
3 of this paragraph through rulemaking. Such re-
4 quirements shall ensure that such files are lim-
5 ited to an appropriate size, do not include infor-
6 mation that is duplicative of information con-
7 tained in the same file or in other files made
8 available under such subsection, are made avail-
9 able in a widely-available format that allows for
10 information contained in such files to be com-
11 pared across group health plans and group
12 health insurance coverage, and are accessible to
13 individuals at no cost and without the need to
14 establish a user account or provide other cre-
15 dentials.

16 “(B) REAL-TIME PROVISION OF INFORMA-
17 TION.—

18 “(i) IN GENERAL.—Subject to clause
19 (ii), beginning January 1, 2026, rate and
20 payment information required to be made
21 available by a group health plan or health
22 insurance issuer under subsection (a)(9)
23 shall, in addition to being made available
24 in the manner described in subparagraph
25 (A), be made available through an applica-

1 tion program interface (or successor tech-
2 nology) that provides access to such infor-
3 mation in real time and that meets such
4 technical standards as may be specified by
5 the Secretary.

6 “(ii) EXEMPTION FOR CERTAIN PLANS
7 OR COVERAGE.—Clause (i) shall not apply
8 with respect to information described in
9 such clause required to be made available
10 by a group health plan or health insurance
11 issuer offering health insurance coverage if
12 such plan or coverage, as applicable, pro-
13 vides benefits for fewer than 500 partici-
14 pants and beneficiaries.

15 “(3) USER GUIDE.—The Secretary, Secretary
16 of Health and Human Services, and Secretary of the
17 Treasury shall jointly make available to the public
18 instructions written in plain language explaining how
19 individuals may search for information described in
20 paragraph (1) in files submitted in accordance with
21 paragraph (2).

22 “(4) ANNUAL SUMMARY.—For each year (be-
23 ginning with 2025), each group health plan and
24 health insurance issuer offering group health insur-
25 ance coverage shall make public a machine-readable

1 file meeting such standards as established by the
2 Secretary under paragraph (2) containing a sum-
3 mary of all rate and payment information made pub-
4 lic by such plan or issuer with respect to such plan
5 or coverage during such year (such as averages of all
6 such information so made public).

7 “(e) ATTESTATION.—Each group health plan and
8 health insurance issuer offering group health insurance
9 coverage shall annually submit to the Secretary an attesta-
10 tion of such plan’s or such coverage’s compliance with the
11 provisions of this section along with a link to disclosures
12 made in accordance with subsection (a).

13 “(f) DEFINITIONS.—In this subsection:

14 “(1) PARTICIPATING PROVIDER.—The term
15 ‘participating provider’ has the meaning given such
16 term in section 716 and includes a participating fa-
17 cility.

18 “(2) IN-NETWORK RATE.—The term ‘in-net-
19 work rate’ means, with respect to a group health
20 plan or group health insurance coverage and an item
21 or service furnished by a provider that is a partici-
22 pating provider with respect to such plan or cov-
23 erage and item or service, the contracted rate (re-
24 flected as a dollar amount) in effect between such

1 plan or coverage and such provider for such item or
2 service.”.

3 (B) CLERICAL AMENDMENT.—The table of
4 contents in section 1 of such Act is amended by
5 striking the item relating to section 719 and in-
6 serting the following new item:

“Sec. 719. Price transparency requirements.”.

7 (2) IRC.—

8 (A) IN GENERAL.—Section 9819 of the In-
9 ternal Revenue Code of 1986 is amended to
10 read as follows:

11 **“SEC. 9819. PRICE TRANSPARENCY REQUIREMENTS.**

12 “(a) IN GENERAL.—A group health plan shall make
13 available to the public accurate and timely disclosures of
14 the following information:

15 “(1) Claims payment policies and practices.

16 “(2) Periodic financial disclosures.

17 “(3) Data on enrollment.

18 “(4) Data on disenrollment.

19 “(5) Data on the number of claims that are de-
20 nied.

21 “(6) Data on rating practices.

22 “(7) Information on cost-sharing and payments
23 with respect to any out-of-network coverage (or with
24 respect to any item and service furnished under such
25 a plan that does not use a network of providers).

1 “(8) Information on participant and beneficiary
2 rights under this part.

3 “(9) Rate and payment information described
4 in subsection (d).

5 “(10) Other information as determined appro-
6 priate by the Secretary.

7 Rate and payment information described in paragraph (9)
8 shall be made available to the public not later than Janu-
9 ary 10, 2025, and not later than the tenth day of every
10 month thereafter, in the manner described in subsection
11 (d)(2)(A), and, beginning on January 1, 2027, in real-time
12 through an application program interface (or successor
13 technology) described in subsection (d)(2)(B).

14 “(b) USE OF PLAIN LANGUAGE.—The information
15 required to be submitted under subsection (a) shall be pro-
16 vided in plain language. The term ‘plain language’ means
17 language that the intended audience, including individuals
18 with limited English proficiency, can readily understand
19 and use because that language is clear, concise, well-orga-
20 nized, accurately describes the information, and follows
21 other best practices of plain language writing. The Sec-
22 retary, jointly with the Secretary of Health and Human
23 Services and the Secretary of Labor, shall develop and
24 issue standards for plain language writing for purposes
25 of this section and shall develop a standardized reporting

1 template and standardized definitions of terms to allow
2 for comparison across group health plans and health in-
3 surance coverage.

4 “(c) COST SHARING TRANSPARENCY.—

5 “(1) IN GENERAL.—A group health plan shall,
6 upon request of a participant or beneficiary and in
7 a timely manner, provide to the participant or bene-
8 ficiary a statement of the amount of cost-sharing
9 (including deductibles, copayments, and coinsurance)
10 under the participant’s or beneficiary’s plan that the
11 participant or beneficiary would be responsible for
12 paying with respect to the furnishing of a specific
13 item or service by a provider. At a minimum, such
14 information shall include the information specified in
15 paragraph (2) and shall be made available at no cost
16 to the participant or beneficiary through a self-serv-
17 ice tool that meets the requirements of paragraph
18 (3) or through a paper or phone disclosure, at the
19 option of the participant or beneficiary, that meets
20 such requirements as the Secretary may specify.

21 “(2) SPECIFIED INFORMATION.—For purposes
22 of paragraph (1), the information specified in this
23 paragraph is, with respect to an item or service for
24 which benefits are available under a group health

1 plan furnished by a health care provider to a partici-
2 pant or beneficiary of such plan, the following:

3 “(A) If such provider is a participating
4 provider with respect to such item or service,
5 the in-network rate (as defined in subsection
6 (f)) for such item or service and for any other
7 item or service that is inherent in the fur-
8 nishing of the item or service that is the subject
9 of such request.

10 “(B) If such provider is not a participating
11 provider, the allowed amount, percentage of
12 billed charges, or other rate that such plan will
13 recognize as payment for such item or service,
14 along with a notice that such individual may be
15 liable for additional charges billed by such pro-
16 vider.

17 “(C) The estimated amount of cost sharing
18 (including deductibles, copayments, and coin-
19 surance) that the participant or beneficiary will
20 incur for such item or service (which, in the
21 case such item or service is to be furnished by
22 a provider described in subparagraph (B), shall
23 be calculated using the amount or rate de-
24 scribed in such subparagraph (or, in the case
25 such plan uses a percentage of billed charges to

1 determined the amount of payment for such
2 provider, using a reasonable estimate of such
3 percentage of such charges)).

4 “(D) The amount the participant or bene-
5 ficiary has already accumulated with respect to
6 any deductible or out of pocket maximum under
7 the plan (broken down, in the case separate
8 deductibles or maximums apply to separate par-
9 ticipants and beneficiaries enrolled in the plan,
10 by such separate deductibles or maximums, in
11 addition to any cumulative deductible or max-
12 imum).

13 “(E) Any shared savings or other benefit
14 available to the participant or beneficiary with
15 respect to such item or service.

16 “(F) In the case such plan imposes any
17 frequency or volume limitations with respect to
18 such item or service (excluding medical neces-
19 sity determinations), the amount that such par-
20 ticipant or beneficiary has accrued towards such
21 limitation with respect to such item or service.

22 “(G) Any prior authorization, concurrent
23 review, step therapy, fail first, or similar re-
24 quirements applicable to coverage of such item
25 or service under such plan.

1 “(3) SELF-SERVICE TOOL.—For purposes of
2 paragraph (1), a self-service tool established by a
3 group health plan meets the requirements of this
4 paragraph if such tool—

5 “(A) is based on an Internet website, mo-
6 bile application, or other platform determined
7 appropriate by the Secretary;

8 “(B) provides for real-time responses to re-
9 quests described in paragraph (1);

10 “(C) is updated in a manner such that in-
11 formation provided through such tool is accu-
12 rate at the time such request is made;

13 “(D) allows such a request to be made
14 with respect to an item or service furnished
15 by—

16 “(i) a specific provider that is a par-
17 ticipating provider with respect to such
18 item or service;

19 “(ii) all providers that are partici-
20 pating providers with respect to such item
21 or service for purposes of facilitating price
22 comparisons; or

23 “(iii) a provider that is not described
24 in clause (ii); and

1 “(E) provides that such a request may be
2 made with respect to an item or service through
3 use of the billing code for such item or service
4 or through use of a descriptive term for such
5 item or service.

6 The Secretary may require such tool, as a condition
7 of complying with subparagraph (E), to link multiple
8 billing codes to a single descriptive term if the Sec-
9 retary determines that the billing codes to be so
10 linked correspond to items and services.

11 “(4) PROVIDER TOOL.—A group health plan
12 shall permit providers to learn the amount of cost-
13 sharing (including deductibles, copayments, and co-
14 insurance) that would apply under an individual’s
15 plan that the individual would be responsible for
16 paying with respect to the furnishing of a specific
17 item or service by another provider in a timely man-
18 ner upon the request of the provider and with the
19 consent of such individual in the same manner and
20 to the same extent as if such request has been made
21 by such individual. As part of any tool used to facili-
22 tate such requests from a provider, such plan may
23 include functionality that—

24 “(A) allows providers to submit the notifi-
25 cations to such plan or coverage required under

1 section 2799B–6 of the Public Health Services
2 Act; and

3 “(B) provides for notifications required
4 under section 9816(f) to such an individual.

5 “(d) RATE AND PAYMENT INFORMATION.—

6 “(1) IN GENERAL.—For purposes of subsection
7 (a)(9), the rate and payment information described
8 in this subsection is, with respect to a group health
9 plan, the following:

10 “(A) With respect to each item or service
11 (other than a drug) for which benefits are avail-
12 able under such plan, the in-network rate (in a
13 dollar amount) in effect as of the first day of
14 the plan year during which such information is
15 submitted with each provider (identified by na-
16 tional provider identifier) that is a participating
17 provider with respect to such item or service
18 (or, in the case such rate is not available in a
19 dollar amount, such formulae, pricing meth-
20 odologies, or other information used to calculate
21 such rate).

22 “(B) With respect to each dosage form and
23 indication of each drug (identified by national
24 drug code) for which benefits are available
25 under such plan—

1 “(i) the in-network rate (in a dollar
2 amount) in effect as of the first day of the
3 plan year during which such information is
4 submitted with each provider (identified by
5 national provider identifier) that is a par-
6 ticipating provider with respect to such
7 drug (or, in the case such rate is not avail-
8 able in a dollar amount, such formulae,
9 pricing methodologies, or other information
10 used to calculate such rate); and

11 “(ii) the average amount paid by such
12 plan (net of rebates, discounts, and price
13 concessions) for such drug dispensed or
14 administered during the 90-day period be-
15 ginning 180 days before such date of sub-
16 mission to each provider that was a par-
17 ticipating provider with respect to such
18 drug, broken down by each such provider
19 (identified by national provider identifier),
20 other than such an amount paid to a pro-
21 vider that, during such period, submitted
22 fewer than 20 claims for such drug to such
23 plan or coverage.

24 “(C) With respect to each item or service
25 for which benefits are available under such

1 plan, the amount billed, and the amount al-
2 lowed by the plan, for each such item or service
3 furnished during the 90-day period specified in
4 subparagraph (B) by a provider that was not a
5 participating provider with respect to such item
6 or service, broken down by each such provider
7 (identified by national provider identifier), other
8 than items and services with respect to which
9 fewer than 20 claims for such item or service
10 were submitted to such plan or coverage during
11 such period.

12 Such rate and payment information shall be made
13 available with respect to each individual item or
14 service, regardless of whether such item or service is
15 paid for as part of a bundled payment, episode of
16 care, value-based payment arrangement, or other-
17 wise.

18 “(2) MANNER OF PUBLICATION.—

19 “(A) IN GENERAL.—Rate and payment in-
20 formation required to be made available under
21 subsection (a)(9) shall be so made available in
22 dollar amounts through 3 separate machine-
23 readable files corresponding to the information
24 described in each of subparagraphs (A) through
25 (C) of paragraph (1) that meet such require-

1 ments as specified by the Secretary not later
2 than 180 days after the date of the enactment
3 of this paragraph through rulemaking. Such re-
4 quirements shall ensure that such files are lim-
5 ited to an appropriate size, do not include infor-
6 mation that is duplicative of information con-
7 tained in other files made available under such
8 subsection, are made available in a widely-avail-
9 able format that allows for information con-
10 tained in such files to be compared across
11 group health plans, and are accessible to indi-
12 viduals at no cost and without the need to es-
13 tablish a user account or provide other creden-
14 tials.

15 “(B) REAL-TIME PROVISION OF INFORMA-
16 TION.—

17 “(i) IN GENERAL.—Subject to clause
18 (ii), beginning January 1, 2026, rate and
19 payment information required to be made
20 available by a group health plan under
21 subsection (a)(9) shall, in addition to being
22 made available in the manner described in
23 subparagraph (A), be made available
24 through an application program interface
25 (or successor technology) that provides ac-

1 cess to such information in real time and
2 that meets such technical standards as
3 may be specified by the Secretary.

4 “(ii) EXEMPTION FOR CERTAIN PLANS
5 AND COVERAGE.—Clause (i) shall not
6 apply with respect to information described
7 in such clause required to be made avail-
8 able by a group health plan if such plan
9 provides benefits for fewer than 500 par-
10 ticipants and beneficiaries.

11 “(3) USER GUIDE.—The Secretary, Secretary
12 of Health and Human Services, and Secretary of
13 Labor shall jointly make available to the public in-
14 structions written in plain language explaining how
15 individuals may search for information described in
16 paragraph (1) in files submitted in accordance with
17 paragraph (2).

18 “(4) ANNUAL SUMMARY.—For each year (be-
19 ginning with 2025), each group health plan shall
20 make public a machine-readable file meeting such
21 standards as established by the Secretary under
22 paragraph (2) containing a summary of all rate and
23 payment information made public by such plan with
24 respect to such plan or coverage during such year

1 (such as averages of all such information so made
2 public).

3 “(e) ATTESTATION.—Each group health plan shall
4 annually submit to the Secretary an attestation of such
5 plan’s compliance with the provisions of this section along
6 with a link to disclosures made in accordance with sub-
7 section (a).

8 “(f) DEFINITIONS.—In this subsection:

9 “(1) PARTICIPATING PROVIDER.—The term
10 ‘participating provider’ has the meaning given such
11 term in section 9816 and includes a participating fa-
12 cility.

13 “(2) IN-NETWORK RATE.—The term ‘in-net-
14 work rate’ means, with respect to a group health
15 plan and an item or service furnished by a provider
16 that is a participating provider with respect to such
17 plan and item or service, the contracted rate (re-
18 flected as a dollar amount) in effect between such
19 plan and such provider for such item or service.”.

20 (B) CLERICAL AMENDMENT.—The item re-
21 lating to section 9819 in the table of sections
22 for subchapter B of chapter 100 of the Internal
23 Revenue Code of 1986 is amended to read as
24 follows:

“Sec. 9819. Price transparency requirements.”.

1 (3) PHSA.—Section 2799A–4 of the Public
2 Health Service Act (42 U.S.C. 300gg–114) is
3 amended to read as follows:

4 **“SEC. 2799A–4. PRICE TRANSPARENCY REQUIREMENTS.**

5 “(a) IN GENERAL.—A group health plan, and a
6 health insurance issuer offering group or individual health
7 insurance coverage, shall make available to the public ac-
8 curate and timely disclosures of the following information:

9 “(1) Claims payment policies and practices.

10 “(2) Periodic financial disclosures.

11 “(3) Data on enrollment.

12 “(4) Data on disenrollment.

13 “(5) Data on the number of claims that are de-
14 nied.

15 “(6) Data on rating practices.

16 “(7) Information on cost-sharing and payments
17 with respect to any out-of-network coverage (or with
18 respect to any item and service furnished under such
19 a plan or such group or individual health insurance
20 coverage that does not use a network of providers).

21 “(8) Information on enrollee rights under this
22 part.

23 “(9) Rate and payment information described
24 in subsection (d).

1 “(10) Other information as determined appro-
2 priate by the Secretary.

3 Rate and payment information described in paragraph (9)
4 shall be made available to the public not later than Janu-
5 ary 10, 2025, and not later than the tenth day of every
6 month thereafter, in the manner described in subsection
7 (d)(2)(A), and, beginning on January 1, 2027, in real-time
8 through an application program interface (or successor
9 technology) described in subsection (d)(2)(B).

10 “(b) USE OF PLAIN LANGUAGE.—The information
11 required to be submitted under subsection (a) shall be pro-
12 vided in plain language. The term ‘plain language’ means
13 language that the intended audience, including individuals
14 with limited English proficiency, can readily understand
15 and use because that language is clear, concise, well-orga-
16 nized, accurately describes the information, and follows
17 other best practices of plain language writing. The Sec-
18 retary, jointly with the Secretary of Labor and the Sec-
19 retary of the Treasury, shall develop and issue standards
20 for plain language writing for purposes of this section and
21 shall develop a standardized reporting template and stand-
22 ardized definitions of terms to allow for comparison across
23 group health plans and health insurance coverage.

24 “(c) COST SHARING TRANSPARENCY.—

1 “(1) IN GENERAL.—A group health plan, and a
2 health insurance issuer offering group or individual
3 health insurance coverage, shall, upon request of an
4 enrollee and in a timely manner, provide to the en-
5 rollee a statement of the amount of cost-sharing (in-
6 cluding deductibles, copayments, and coinsurance)
7 under the enrollee’s plan or coverage that the en-
8 rollee would be responsible for paying with respect
9 to the furnishing of a specific item or service by a
10 provider. At a minimum, such information shall in-
11 clude the information specified in paragraph (2) and
12 shall be made available at no cost to the enrollee
13 through a self-service tool that meets the require-
14 ments of paragraph (3) or through a paper or phone
15 disclosure, at the option of the enrollee, that meets
16 such requirements as the Secretary may specify.

17 “(2) SPECIFIED INFORMATION.—For purposes
18 of paragraph (1), the information specified in this
19 paragraph is, with respect to an item or service for
20 which benefits are available under a group health
21 plan or group or individual health insurance cov-
22 erage (as applicable) furnished by a health care pro-
23 vider to an enrollee of such plan or coverage, the fol-
24 lowing:

1 “(A) If such provider is a participating
2 provider with respect to such item or service,
3 the in-network rate (as defined in subsection
4 (f)) for such item or service and for any other
5 item or service that is inherent in the fur-
6 nishing of the item or service that is the subject
7 of such request.

8 “(B) If such provider is not a participating
9 provider, the allowed amount, percentage of
10 billed charges, or other rate that such plan or
11 coverage will recognize as payment for such
12 item or service, along with a notice that such
13 enrollee may be liable for additional charges
14 billed by such provider.

15 “(C) The estimated amount of cost sharing
16 (including deductibles, copayments, and coin-
17 surance) that the enrollee will incur for such
18 item or service (which, in the case such item or
19 service is to be furnished by a provider de-
20 scribed in subparagraph (B), shall be calculated
21 using the amount or rate described in such sub-
22 paragraph (or, in the case such plan or issuer
23 uses a percentage of billed charges to deter-
24 mined the amount of payment for such pro-

1 vider, using a reasonable estimate of such per-
2 centage of such charges)).

3 “(D) The amount the enrollee has already
4 accumulated with respect to any deductible or
5 out of pocket maximum under the plan or cov-
6 erage (broken down, in the case separate
7 deductibles or maximums apply to separate en-
8 rollees in the plan or coverage, by such separate
9 deductibles or maximums, in addition to any
10 cumulative deductible or maximum).

11 “(E) Any shared savings or other benefit
12 available to the enrollee with respect to such
13 item or service.

14 “(F) In the case such plan or coverage im-
15 poses any frequency or volume limitations with
16 respect to such item or service (excluding med-
17 ical necessity determinations), the amount that
18 such enrollee has accrued towards such limita-
19 tion with respect to such item or service.

20 “(G) Any prior authorization, concurrent
21 review, step therapy, fail first, or similar re-
22 quirements applicable to coverage of such item
23 or service under such plan or group or indi-
24 vidual health insurance coverage.

1 “(3) SELF-SERVICE TOOL.—For purposes of
2 paragraph (1), a self-service tool established by a
3 group health plan or health insurance issuer offering
4 group or individual health insurance coverage meets
5 the requirements of this paragraph if such tool—

6 “(A) is based on an Internet website, mo-
7 bile application, or other platform determined
8 appropriate by the Secretary;

9 “(B) provides for real-time responses to re-
10 quests described in paragraph (1);

11 “(C) is updated in a manner such that in-
12 formation provided through such tool is accu-
13 rate at the time such request is made;

14 “(D) allows such a request to be made
15 with respect to an item or service furnished
16 by—

17 “(i) a specific provider that is a par-
18 ticipating provider with respect to such
19 item or service;

20 “(ii) all providers that are partici-
21 pating providers with respect to such plan
22 and such item or service for purposes of
23 facilitating price comparisons; or

24 “(iii) a provider that is not described
25 in clause (ii); and

1 “(E) provides that such a request may be
2 made with respect to an item or service through
3 use of the billing code for such item or service
4 or through use of a descriptive term for such
5 item or service.

6 The Secretary may require such tool, as a condition
7 of complying with subparagraph (E), to link multiple
8 billing codes to a single descriptive term if the Sec-
9 retary determines that the billing codes to be so
10 linked correspond to items and services.

11 “(4) PROVIDER TOOL.—A group health plan,
12 and a health insurance issuer offering group or indi-
13 vidual health insurance coverage, shall permit pro-
14 viders to learn the amount of cost-sharing (including
15 deductibles, copayments, and coinsurance) that
16 would apply under an individual’s plan or coverage
17 that the individual would be responsible for paying
18 with respect to the furnishing of a specific item or
19 service by another provider in a timely manner upon
20 the request of the provider and with the consent of
21 such individual in the same manner and to the same
22 extent as if such request has been made by such in-
23 dividual. As part of any tool used to facilitate such
24 requests from a provider, such plan or issuer offer-

1 ing health insurance coverage may include
2 functionality that—

3 “(A) allows providers to submit the notifi-
4 cations to such plan or coverage required under
5 section 2799B–6; and

6 “(B) provides for notifications required
7 under section 2799A–1(f) to such an individual.

8 “(d) RATE AND PAYMENT INFORMATION.—

9 “(1) IN GENERAL.—For purposes of subsection
10 (a)(9), the rate and payment information described
11 in this subsection is, with respect to a group health
12 plan or group or individual health insurance cov-
13 erage (as applicable), the following:

14 “(A) With respect to each item or service
15 (other than a drug) for which benefits are avail-
16 able under such plan or coverage, the in-net-
17 work rate (in a dollar amount) in effect as of
18 the first day of the plan year during which such
19 information is submitted with each provider
20 (identified by national provider identifier) that
21 is a participating provider with respect to such
22 item or service (or, in the case such rate is not
23 available in a dollar amount, such formulae,
24 pricing methodologies, or other information
25 used to calculate such rate).

1 “(B) With respect to each dosage form and
2 indication of each drug (identified by national
3 drug code) for which benefits are available
4 under such plan or coverage—

5 “(i) the in-network rate (in a dollar
6 amount) in effect as of the first day of the
7 plan year during which such information is
8 submitted with each provider (identified by
9 national provider identifier) that is a par-
10 ticipating provider with respect to such
11 drug (or, in the case such rate is not avail-
12 able in a dollar amount, such formulae,
13 pricing methodologies, or other information
14 used to calculate such rate); and

15 “(ii) the average amount paid by such
16 plan (net of rebates, discounts, and price
17 concessions) for such drug dispensed or
18 administered during the 90-day period be-
19 ginning 180 days before such date of sub-
20 mission to each provider that was a par-
21 ticipating provider with respect to such
22 drug, broken down by each such provider
23 (identified by national provider identifier),
24 other than such an amount paid to a pro-
25 vider that, during such period, submitted

1 fewer than 20 claims for such drug to such
2 plan or coverage.

3 “(C) With respect to each item or service
4 for which benefits are available under such plan
5 or coverage, the amount billed, and the amount
6 allowed by the plan or coverage, for each such
7 item or service furnished during the 90-day pe-
8 riod specified in subparagraph (B) by a pro-
9 vider that was not a participating provider with
10 respect to such item or service, broken down by
11 each such provider (identified by national pro-
12 vider identifier), other than items and services
13 with respect to which fewer than 20 claims for
14 such item or service were submitted to such
15 plan or coverage during such period.

16 Such rate and payment information shall be made
17 available with respect to each individual item or
18 service, regardless of whether such item or service is
19 paid for as part of a bundled payment, episode of
20 care, value-based payment arrangement, or other-
21 wise.

22 “(2) MANNER OF PUBLICATION.—

23 “(A) IN GENERAL.—Rate and payment in-
24 formation required to be made available under
25 subsection (a)(9) shall be so made available in

1 dollar amounts through 3 separate machine-
2 readable files corresponding to the information
3 described in each of subparagraphs (A) through
4 (C) of paragraph (1) that meet such require-
5 ments as specified by the Secretary not later
6 than 180 days after the date of the enactment
7 of this paragraph through rulemaking. Such re-
8 quirements shall ensure that such files are lim-
9 ited to an appropriate size, do not include infor-
10 mation that is duplicative of information con-
11 tained in other files made available under such
12 subsection, are made available in a widely-avail-
13 able format that allows for information con-
14 tained in such files to be compared across
15 group health plans and group or individual
16 health insurance coverage, and are accessible to
17 individuals at no cost and without the need to
18 establish a user account or provide other cre-
19 dentials.

20 “(B) REAL-TIME PROVISION OF INFORMA-
21 TION.—

22 “(i) IN GENERAL.—Subject to clause
23 (ii), beginning January 1, 2026, rate and
24 payment information required to be made
25 available by a group health plan or health

1 insurance issuer under subsection (a)(9)
2 shall, in addition to being made available
3 in the manner described in subparagraph
4 (A), be made available through an applica-
5 tion program interface (or successor tech-
6 nology) that provides access to such infor-
7 mation in real time and that meets such
8 technical standards as may be specified by
9 the Secretary.

10 “(ii) EXEMPTION FOR CERTAIN PLANS
11 AND COVERAGE.—Clause (i) shall not
12 apply with respect to information described
13 in such clause required to be made avail-
14 able by a group health plan or health in-
15 surance issuer offering health insurance
16 coverage if such plan or coverage, as appli-
17 cable, provides benefits for fewer than 500
18 enrollees.

19 “(3) USER GUIDE.—The Secretary, Secretary
20 of Labor, and Secretary of the Treasury shall jointly
21 make available to the public instructions written in
22 plain language explaining how individuals may
23 search for information described in paragraph (1) in
24 files submitted in accordance with paragraph (2).

1 “(4) ANNUAL SUMMARY.—For each year (be-
2 ginning with 2025), each group health plan and
3 health insurance issuer offering group or individual
4 health insurance coverage shall make public a ma-
5 chine-readable file meeting such standards as estab-
6 lished by the Secretary under paragraph (2) con-
7 taining a summary of all rate and payment informa-
8 tion made public by such plan or issuer with respect
9 to such plan or coverage during such year (such as
10 averages of all such information so made public).

11 “(e) ATTESTATION.—Each group health plan and
12 health insurance issuer offering group or individual health
13 insurance coverage shall annually submit to the Secretary
14 an attestation of such plan’s or such coverage’s compliance
15 with the provisions of this section along with a link to dis-
16 closures made in accordance with subsection (a).

17 “(f) DEFINITIONS.—In this subsection:

18 “(1) PARTICIPATING PROVIDER.—The term
19 ‘participating provider’ has the meaning given such
20 term in section 2799A–1 and includes a partici-
21 pating facility.

22 “(2) IN-NETWORK RATE.—The term ‘in-net-
23 work rate’ means, with respect to a group health
24 plan or group or individual health insurance cov-
25 erage and an item or service furnished by a provider

1 that is a participating provider with respect to such
2 plan or coverage and item or service, the contracted
3 rate (reflected as a dollar amount) in effect between
4 such plan or coverage and such provider for such
5 item or service.”.

6 (b) REPORTS TO CONGRESS.—

7 (1) QUALITY REPORT.—Not later than 1 year
8 after the date of enactment of this subsection, the
9 Secretary of Labor shall submit to Congress a report
10 on the feasibility of including data relating to the
11 quality of health care items and services with the
12 price transparency information required to be made
13 available under the amendments made by subsection
14 (a). Such report shall include recommendations for
15 legislative and regulatory actions to identify appro-
16 priate metrics for assessing and comparing quality
17 of care.

18 (2) TRANSPARENCY DATA ASSESSMENT.—Not
19 later than January 1, 2026, and biannually there-
20 after through 2032, the Secretary shall submit to
21 Congress, and make publicly available on a website
22 of the Department of Labor, a report with respect
23 to the information described in section 719 of the
24 Employee Retirement Income Security Act (29
25 U.S.C. 1185h) (as amended by the “Transparency

1 in Coverage Act of 2023”), assessing the differences
2 in commercial negotiated prices—

3 (A) between rural and urban markets;

4 (B) in the individual, small-employer, and
5 large-employer markets;

6 (C) in consolidated and non-consolidated
7 provider markets;

8 (D) between non-profit and for-profit hos-
9 pitals; and

10 (E) between non-profit and for-profit in-
11 surers.

12 (c) EFFECTIVE DATE.—

13 (1) IN GENERAL.—The amendments made by
14 subsection (a) shall apply to plan years beginning on
15 or after January 1, 2025.

16 (2) CONTINUED APPLICABILITY OF RULES FOR
17 PREVIOUS YEARS.—Nothing in the amendments
18 made by subsection (a) may be construed as affect-
19 ing the applicability of the rule entitled “Trans-
20 parency in Coverage” published by the Department
21 of the Treasury, the Department of Labor, and the
22 Department of Health and Human Services on No-
23 vember 12, 2020 (85 Fed. Reg. 72158) for plan
24 years beginning before January 1, 2025.

1 **SEC. 3. PHARMACY BENEFIT MANAGER TRANSPARENCY.**

2 (a) ERISA.—

3 (1) IN GENERAL.—Subtitle B of title I of the
4 Employee Retirement Income Security Act of 1974
5 (29 U.S.C. 1021 et seq.) is amended—

6 (A) in subpart B of part 7 (29 U.S.C.
7 1185 et seq.), by adding at the end the fol-
8 lowing:

9 **“SEC. 726. OVERSIGHT OF PHARMACY BENEFITS MANAGER**
10 **SERVICES.**

11 “(a) IN GENERAL.—For plan years beginning on or
12 after January 1, 2025, a group health plan (or health in-
13 surance issuer offering group health insurance coverage
14 in connection with such a plan) or an entity or subsidiary
15 providing pharmacy benefits management services on be-
16 half of such a plan or issuer may not enter into a contract
17 with a drug manufacturer, distributor, wholesaler, switch,
18 patient or copay assistance program administrator, phar-
19 macy, subcontractor, rebate aggregator, or any associated
20 third party that limits or delays the disclosure of informa-
21 tion to plan administrators in such a manner that prevents
22 the plan or issuer, or an entity or subsidiary providing
23 pharmacy benefits management services on behalf of a
24 plan or issuer, from making or substantiating the reports
25 described in subsection (b).

26 “(b) REPORTS.—

1 “(1) IN GENERAL.—For plan years beginning
2 on or after January 1, 2025, not less frequently
3 than quarterly (and upon request by the plan admin-
4 istrator), a group health plan or health insurance
5 issuer offering group health insurance coverage, or
6 an entity providing pharmacy benefits management
7 services on behalf of a group health plan or an
8 issuer providing group health insurance coverage,
9 shall submit to the plan administrator (as defined in
10 section 3(16)(A)) of such plan or coverage a report
11 in accordance with this subsection, and make such
12 report available to the plan administrator in a ma-
13 chine-readable format (or as may be determined by
14 the Secretary, other formats). Each such report
15 shall include, with respect to the applicable group
16 health plan or health insurance coverage—

17 “(A) information collected from a patient
18 or copay assistance program administrator by
19 such entity on the total amount of copayment
20 assistance dollars paid, or copayment cards ap-
21 plied, or other discounts that were funded by
22 the drug manufacturer with respect to the par-
23 ticipants and beneficiaries in such plan or cov-
24 erage;

1 “(B) total gross spending on prescription
2 drugs by the plan or coverage during the re-
3 porting period;

4 “(C) total amount received, or expected to
5 be received, by the plan or coverage from any
6 entities, in rebates, fees, alternative discounts,
7 and all other remuneration received from the
8 entity or any third party (including group pur-
9 chasing organizations) other than the plan ad-
10 ministrator, related to utilization of drug or
11 drug spending under such plan or coverage dur-
12 ing the reporting period;

13 “(D) the total net spending on prescription
14 drugs by the plan or coverage during such re-
15 porting period;

16 “(E) amounts paid, directly or indirectly,
17 in rebates, fees, or any other type of compensa-
18 tion (as defined in section
19 408(b)(2)(B)(ii)(dd)(AA)) to brokerage houses,
20 brokers, consultants, advisors, or any other in-
21 dividual or firm for the referral of the group
22 health plan’s or health insurance issuer’s busi-
23 ness to the pharmacy benefits manager, identi-
24 fied by the recipient of such amounts;

1 “(F)(i) an explanation of any benefit de-
2 sign parameters that encourage or require par-
3 ticipants and beneficiaries in the plan or cov-
4 erage to fill prescriptions at mail order, spe-
5 cialty, or retail pharmacies that are affiliated
6 with or under common ownership with the enti-
7 ty providing pharmacy benefit management
8 services under such plan or coverage, including
9 mandatory mail and specialty home delivery
10 programs, retail and mail auto-refill programs,
11 and cost-sharing assistance incentives funded
12 by an entity providing pharmacy benefit man-
13 agement services;

14 “(ii) the percentage of total prescrip-
15 tions charged to the plan, issuer, or par-
16 ticipants and beneficiaries in such plan or
17 coverage, that were dispensed by mail
18 order, specialty, or retail pharmacies that
19 are affiliated with or under common own-
20 ership with the entity providing pharmacy
21 benefit management services; and

22 “(iii) a list of all drugs dispensed by
23 such affiliated pharmacy or pharmacy
24 under common ownership and charged to
25 the plan, issuer, or participants and bene-

1 beneficiaries of the plan, during the applicable
2 period, and, with respect to each drug—

3 “(I)(aa) the amount charged, per
4 dosage unit, per 30-day supply, and
5 per 90-day supply, with respect to
6 participants and beneficiaries in the
7 plan or coverage, to the plan or
8 issuer; and

9 “(bb) the amount charged,
10 per dosage unit, per 30-day sup-
11 ply, and per 90-day supply, to
12 participants and beneficiaries;

13 “(II) the median amount charged
14 to the plan or issuer, per dosage unit,
15 per 30-day supply, and per 90-day
16 supply, including amounts paid by the
17 participants and beneficiaries, when
18 the same drug is dispensed by other
19 pharmacies that are not affiliated with
20 or under common ownership with the
21 entity and that are included in the
22 pharmacy network of such plan or
23 coverage;

24 “(III) the interquartile range of
25 the costs, per dosage unit, per 30-day

1 supply, and per 90-day supply, includ-
2 ing amounts paid by the participants
3 and beneficiaries, when the same drug
4 is dispensed by other pharmacies that
5 are not affiliated with or under com-
6 mon ownership with the entity and
7 that are included in the pharmacy
8 network of that plan or coverage;

9 “(IV) the lowest cost, per dosage
10 unit, per 30-day supply, and per 90-
11 day supply, for such drug, including
12 amounts charged to the plan and par-
13 ticipants and beneficiaries, that is
14 available from any pharmacy included
15 in the network of the plan or cov-
16 erage;

17 “(V) the net acquisition cost per
18 dosage unit, per 30-day supply, and
19 per 90-day supply, if the drug is sub-
20 ject to a maximum price discount; and

21 “(VI) other information with re-
22 spect to the cost of the drug, as deter-
23 mined by the Secretary, such as aver-
24 age sales price, wholesale acquisition
25 cost, and national average drug acqui-

1 sition cost per dosage unit or per 30-
2 day supply, and per 90-day supply,
3 for such drug, including amounts
4 charged to the plan or issuer and par-
5 ticipants and beneficiaries among all
6 pharmacies included in the network of
7 such plan or coverage; and

8 “(G) in the case of a large employer—

9 “(i) a list of each drug covered by
10 such plan, issuer, or entity providing phar-
11 macy benefits management services for
12 which a claim was filed during the report-
13 ing period, including, with respect to each
14 such drug during the reporting period—

15 “(I) the brand name, generic or
16 non-proprietary name, and the Na-
17 tional Drug Code;

18 “(II)(aa) the number of partici-
19 pants and beneficiaries for whom a
20 claim for such drug was filed during
21 the reporting period, the total number
22 of prescription claims for such drug
23 (including original prescriptions and
24 refills), and the total number of dos-
25 age units and total days supply of

1 such drug for which a claim was filed
2 during the reporting period; and

3 “(bb) with respect to each
4 claim or dosage unit described in
5 item (aa), the type of dispensing
6 channel used, such as retail, mail
7 order, or specialty pharmacy;

8 “(III) the wholesale acquisition
9 cost, listed as cost per days supply
10 and cost per dosage unit on date of
11 dispensing;

12 “(IV) the total out-of-pocket
13 spending by participants and bene-
14 ficiaries on such drug after applica-
15 tion of any benefits under such plan
16 or coverage, including participant and
17 beneficiary spending through copay-
18 ments, coinsurance, and deductibles
19 (but not including any amounts spent
20 by participants and beneficiaries on
21 drugs not covered under such plan or
22 coverage, or for which no claim was
23 submitted to such plan or coverage);

24 “(V) for any drug for which
25 gross spending of the plan or coverage

1 exceeded \$10,000 during the report-
2 ing period—

3 “(aa) a list of all other
4 drugs in the same therapeutic
5 category or class, including brand
6 name drugs, biological products,
7 generic drugs, or biosimilar bio-
8 logical products that are in the
9 same therapeutic category or
10 class as such drug; and

11 “(bb) the rationale for pre-
12 ferred formulary placement of
13 such drug in that therapeutic
14 category or class, if applicable;
15 and

16 “(ii) a list of each therapeutic cat-
17 egory or class of drugs for which a claim
18 was filed under the health plan or health
19 insurance coverage during the reporting
20 period, and, with respect to each such
21 therapeutic category or class of drugs dur-
22 ing the reporting period—

23 “(I) total gross spending by the
24 plan;

1 “(II) the number of participants
2 and beneficiaries who filled a prescrip-
3 tion for a drug in that category or
4 class;

5 “(III) if applicable to that cat-
6 egory or class, a description of the
7 formulary tiers and utilization mecha-
8 nisms (such as prior authorization or
9 step therapy) employed for drugs in
10 that category or class;

11 “(IV) the total out-of-pocket
12 spending by participants and bene-
13 ficiaries, including participant and
14 beneficiary spending through copay-
15 ments, coinsurance, and deductibles;
16 and

17 “(V) for each drug—

18 “(aa) the amount received,
19 or expected to be received, from
20 any entity in rebates, fees, alter-
21 native discounts, or other remu-
22 neration—

23 “(AA) for claims in-
24 curred during the reporting
25 period; or

1 “(BB) that is related to
2 utilization of drugs or drug
3 spending;

4 “(bb) the total net spending,
5 after deducting rebates, price
6 concessions, alternative discounts
7 or other remuneration from drug
8 manufacturers, by the health
9 plan or health insurance coverage
10 on that category or class of
11 drugs; and

12 “(cc) the average net spend-
13 ing per 30-day supply and per
14 90-day supply, incurred by the
15 health plan or health insurance
16 coverage and its participants and
17 beneficiaries, among all drugs
18 within the therapeutic class for
19 which a claim was filed during
20 the reporting period.

21 “(2) PRIVACY REQUIREMENTS.—Health insur-
22 ance issuers offering group health insurance cov-
23 erage and entities providing pharmacy benefits man-
24 agement services on behalf of a group health plan
25 shall provide information under paragraph (1) in a

1 manner consistent with the privacy, security, and
2 breach notification regulations promulgated under
3 section 264(c) of the Health Insurance Portability
4 and Accountability Act of 1996, and shall restrict
5 the use and disclosure of such information according
6 to such privacy regulations.

7 “(3) DISCLOSURE AND REDISCLOSURE.—

8 “(A) LIMITATION TO BUSINESS ASSOCI-
9 ATES.—A group health plan receiving a report
10 under paragraph (1) may disclose such informa-
11 tion only to business associates of such plan as
12 defined in section 160.103 of title 45, Code of
13 Federal Regulations (or successor regulations).

14 “(B) CLARIFICATION REGARDING PUBLIC
15 DISCLOSURE OF INFORMATION.—Nothing in
16 this section prevents a health insurance issuer
17 offering group health insurance coverage or an
18 entity providing pharmacy benefits management
19 services on behalf of a group health plan from
20 placing reasonable restrictions on the public dis-
21 closure of the information contained in a report
22 described in paragraph (1), except that such en-
23 tity may not restrict disclosure of such report
24 to the Department of Health and Human Serv-
25 ices, the Department of Labor, the Department

1 of the Treasury, the Comptroller General of the
2 United States, or applicable State agencies.

3 “(C) LIMITED FORM OF REPORT.—The
4 Secretary shall define through rulemaking a
5 limited form of the report under paragraph (1)
6 required of plan administrators who are drug
7 manufacturers, drug wholesalers, or other direct
8 participants in the drug supply chain, in order
9 to prevent anti-competitive behavior.

10 “(4) REPORT TO GAO.—A health insurance
11 issuer offering group health insurance coverage or
12 an entity providing pharmacy benefits management
13 services on behalf of a group health plan shall sub-
14 mit to the Comptroller General of the United States
15 each of the first 4 reports submitted to a plan ad-
16 ministrator under paragraph (1) with respect to
17 such coverage or plan, and other such reports as re-
18 quested, in accordance with the privacy requirements
19 under paragraph (2), the disclosure and redisclosure
20 standards under paragraph (3), the standards speci-
21 fied pursuant to paragraph (5).

22 “(5) STANDARD FORMAT.—Not later than 6
23 months after the date of enactment of this section,
24 the Secretary shall specify through rulemaking
25 standards for health insurance issuers and entities

1 required to submit reports under paragraph (4) to
2 submit such reports in a standard format.

3 “(c) RULE OF CONSTRUCTION.—Nothing in this sec-
4 tion shall be construed to permit a health insurance issuer,
5 group health plan, or other entity to restrict disclosure to,
6 or otherwise limit the access of, the Department of Labor
7 to a report described in subsection (b)(1) or information
8 related to compliance with subsection (a) by such issuer,
9 plan, or entity.

10 “(d) DEFINITIONS.—In this section:

11 “(1) LARGE EMPLOYER.—The term ‘large em-
12 ployer’ means, in connection with a group health
13 plan with respect to a calendar year and a plan year,
14 an employer who employed an average of at least 50
15 employees on business days during the preceding
16 calendar year and who employs at least 1 employee
17 on the first day of the plan year.

18 “(2) WHOLESALE ACQUISITION COST.—The
19 term ‘wholesale acquisition cost’ has the meaning
20 given such term in section 1847A(c)(6)(B) of the
21 Social Security Act.”; and

22 (B) in section 502 (29 U.S.C. 1132)—

23 (i) in subsection (a)—

24 (I) in paragraph (6), by striking

25 “or (9)” and inserting “(9), or (13)”;

1 (II) in paragraph (10), by strik-
2 ing at the end “or”;

3 (III) in paragraph (11), at the
4 end by striking the period and insert-
5 ing “; or”; and

6 (IV) by adding at the end the fol-
7 lowing new paragraph:

8 “(12) by the Secretary, to enforce section
9 726.”;

10 (ii) in subsection (b)(3), by inserting
11 “and subsections (a)(12) and (c)(13)” be-
12 fore “, the Secretary is not”; and

13 (iii) in subsection (c), by adding at
14 the end the following new paragraph:

15 “(13) SECRETARIAL ENFORCEMENT AUTHORITY
16 RELATING TO OVERSIGHT OF PHARMACY BENEFITS
17 MANAGER SERVICES.—

18 “(A) FAILURE TO PROVIDE TIMELY INFOR-
19 MATION.—The Secretary may impose a penalty
20 against any health insurance issuer or entity
21 providing pharmacy benefits management serv-
22 ices that violates section 726(a) or fails to pro-
23 vide information required under section 726(b)
24 in the amount of \$10,000 for each day during

1 which such violation continues or such informa-
2 tion is not disclosed or reported.

3 “(B) FALSE INFORMATION.—The Sec-
4 retary may impose a penalty against a health
5 insurance issuer or entity providing pharmacy
6 benefits management services that knowingly
7 provides false information under section 726 in
8 an amount not to exceed \$100,000 for each
9 item of false information. Such penalty shall be
10 in addition to other penalties as may be pre-
11 scribed by law.

12 “(C) WAIVERS.—The Secretary may waive
13 penalties under subparagraph (A), or extend
14 the period of time for compliance with a re-
15 quirement of section 726, for an entity in viola-
16 tion of such section that has made a good-faith
17 effort to comply with such section.”.

18 (2) CLERICAL AMENDMENT.—The table of con-
19 tents in section 1 of the Employee Retirement In-
20 come Security Act of 1974 (29 U.S.C. 1001 et seq.)
21 is amended by inserting after the item relating to
22 section 725 the following new item:

 “Sec. 726. Oversight of pharmacy benefits manager services.”.

23 (b) PHSA.—Part D of title XXVII of the Public
24 Health Service Act (42 U.S.C. 300gg–111 et seq.) is
25 amended by adding at the end the following new section:

1 **“SEC. 2799A-11. OVERSIGHT OF PHARMACY BENEFITS MAN-**
2 **AGER SERVICES.**

3 “(a) IN GENERAL.—For plan years beginning on or
4 after January 1, 2025, a group health plan (or health in-
5 surance issuer offering group health insurance coverage
6 in connection with such a plan) or an entity or subsidiary
7 providing pharmacy benefits management services on be-
8 half of such a plan or issuer may not enter into a contract
9 with a drug manufacturer, distributor, wholesaler, switch,
10 patient or copay assistance program administrator, phar-
11 macy, subcontractor, rebate aggregator, or any associated
12 third party that limits or delays the disclosure of informa-
13 tion to plan administrators in such a manner that prevents
14 the plan or issuer, or an entity or subsidiary providing
15 pharmacy benefits management services on behalf of a
16 plan or issuer, from making or substantiating the reports
17 described in subsection (b).

18 “(b) REPORTS.—

19 “(1) IN GENERAL.—For plan years beginning
20 on or after January 1, 2025, not less frequently
21 than quarterly (and upon request by the plan admin-
22 istrator), a group health plan or health insurance
23 issuer offering group health insurance coverage, or
24 an entity providing pharmacy benefits management
25 services on behalf of a group health plan or an
26 issuer providing group health insurance coverage,

1 shall submit to the plan administrator (as defined in
2 section 3(16)(A) of the Employee Retirement In-
3 come Security Act of 1974) of such plan or coverage
4 a report in accordance with this subsection, and
5 make such report available to the plan administrator
6 in a machine-readable format (or as may be deter-
7 mined by the Secretary, other formats). Each such
8 report shall include, with respect to the applicable
9 group health plan or health insurance coverage—

10 “(A) information collected from a patient
11 or copay assistance program administrator by
12 such entity on the total amount of copayment
13 assistance dollars paid, or copayment cards ap-
14 plied, or other discounts that were funded by
15 the drug manufacturer with respect to the par-
16 ticipants and beneficiaries in such plan or cov-
17 erage;

18 “(B) total gross spending on prescription
19 drugs by the plan or coverage during the re-
20 porting period;

21 “(C) total amount received, or expected to
22 be received, by the plan or coverage from any
23 entities, in rebates, fees, alternative discounts,
24 and all other remuneration received from the
25 entity or any third party (including group pur-

1 chasing organizations) other than the plan ad-
2 ministrator, related to utilization of drug or
3 drug spending under such plan or coverage dur-
4 ing the reporting period;

5 “(D) the total net spending on prescription
6 drugs by the plan or coverage during such re-
7 porting period;

8 “(E) amounts paid, directly or indirectly,
9 in rebates, fees, or any other type of compensa-
10 tion (as defined in section
11 408(b)(2)(B)(ii)(dd)(AA) of the Employee Re-
12 tirement Income Security Act of 1974) to bro-
13 kerage houses, brokers, consultants, advisors, or
14 any other individual or firm for the referral of
15 the group health plan’s or health insurance
16 issuer’s business to the pharmacy benefits man-
17 ager, identified by the recipient of such
18 amounts;

19 “(F)(i) an explanation of any benefit de-
20 sign parameters that encourage or require par-
21 ticipants and beneficiaries in the plan or cov-
22 erage to fill prescriptions at mail order, spe-
23 cialty, or retail pharmacies that are affiliated
24 with or under common ownership with the enti-
25 ty providing pharmacy benefit management

1 services under such plan or coverage, including
2 mandatory mail and specialty home delivery
3 programs, retail and mail auto-refill programs,
4 and cost-sharing assistance incentives funded
5 by an entity providing pharmacy benefit man-
6 agement services;

7 “(ii) the percentage of total prescrip-
8 tions charged to the plan, issuer, or par-
9 ticipants and beneficiaries in such plan or
10 coverage, that were dispensed by mail
11 order, specialty, or retail pharmacies that
12 are affiliated with or under common own-
13 ership with the entity providing pharmacy
14 benefit management services; and

15 “(iii) a list of all drugs dispensed by
16 such affiliated pharmacy or pharmacy
17 under common ownership and charged to
18 the plan, issuer, or participants and bene-
19 ficiaries of the plan, during the applicable
20 period, and, with respect to each drug—

21 “(I)(aa) the amount charged, per
22 dosage unit, per 30-day supply, and
23 per 90-day supply, with respect to
24 participants and beneficiaries in the

1 plan or coverage, to the plan or
2 issuer; and

3 “(bb) the amount charged,
4 per dosage unit, per 30-day sup-
5 ply, and per 90-day supply, to
6 participants and beneficiaries;

7 “(II) the median amount charged
8 to the plan or issuer, per dosage unit,
9 per 30-day supply, and per 90-day
10 supply, including amounts paid by the
11 participants and beneficiaries, when
12 the same drug is dispensed by other
13 pharmacies that are not affiliated with
14 or under common ownership with the
15 entity and that are included in the
16 pharmacy network of such plan or
17 coverage;

18 “(III) the interquartile range of
19 the costs, per dosage unit, per 30-day
20 supply, and per 90-day supply, includ-
21 ing amounts paid by the participants
22 and beneficiaries, when the same drug
23 is dispensed by other pharmacies that
24 are not affiliated with or under com-
25 mon ownership with the entity and

1 that are included in the pharmacy
2 network of that plan or coverage;

3 “(IV) the lowest cost, per dosage
4 unit, per 30-day supply, and per 90-
5 day supply, for such drug, including
6 amounts charged to the plan and par-
7 ticipants and beneficiaries, that is
8 available from any pharmacy included
9 in the network of the plan or cov-
10 erage;

11 “(V) the net acquisition cost per
12 dosage unit, per 30-day supply, and
13 per 90-day supply, if the drug is sub-
14 ject to a maximum price discount; and

15 “(VI) other information with re-
16 spect to the cost of the drug, as deter-
17 mined by the Secretary, such as aver-
18 age sales price, wholesale acquisition
19 cost, and national average drug acqui-
20 sition cost per dosage unit or per 30-
21 day supply, and per 90-day supply,
22 for such drug, including amounts
23 charged to the plan or issuer and par-
24 ticipants and beneficiaries among all

1 pharmacies included in the network of
2 such plan or coverage; and

3 “(G) in the case of a large employer—

4 “(i) a list of each drug covered by
5 such plan, issuer, or entity providing phar-
6 macy benefits management services for
7 which a claim was filed during the report-
8 ing period, including, with respect to each
9 such drug during the reporting period—

10 “(I) the brand name, generic or
11 non-proprietary name, and the Na-
12 tional Drug Code;

13 “(II)(aa) the number of partici-
14 pants and beneficiaries for whom a
15 claim for such drug was filed during
16 the reporting period, the total number
17 of prescription claims for such drug
18 (including original prescriptions and
19 refills), and the total number of dos-
20 age units and total days supply of
21 such drug for which a claim was filed
22 during the reporting period; and

23 “(bb) with respect to each
24 claim or dosage unit described in
25 item (aa), the type of dispensing

1 channel used, such as retail, mail
2 order, or specialty pharmacy;

3 “(III) the wholesale acquisition
4 cost, listed as cost per days supply
5 and cost per dosage unit on date of
6 dispensing;

7 “(IV) the total out-of-pocket
8 spending by participants and bene-
9 ficiaries on such drug after applica-
10 tion of any benefits under such plan
11 or coverage, including participant and
12 beneficiary spending through copay-
13 ments, coinsurance, and deductibles
14 (but not including any amounts spent
15 by participants and beneficiaries on
16 drugs not covered under such plan or
17 coverage, or for which no claim was
18 submitted to such plan or coverage);

19 “(V) for any drug for which
20 gross spending of the plan or coverage
21 exceeded \$10,000 during the report-
22 ing period—

23 “(aa) a list of all other
24 drugs in the same therapeutic
25 category or class, including brand

1 name drugs, biological products,
2 generic drugs, or biosimilar bio-
3 logical products that are in the
4 same therapeutic category or
5 class as such drug; and

6 “(bb) the rationale for pre-
7 ferred formulary placement of
8 such drug in that therapeutic
9 category or class, if applicable;
10 and

11 “(ii) a list of each therapeutic cat-
12 egory or class of drugs for which a claim
13 was filed under the health plan or health
14 insurance coverage during the reporting
15 period, and, with respect to each such
16 therapeutic category or class of drugs dur-
17 ing the reporting period—

18 “(I) total gross spending by the
19 plan;

20 “(II) the number of participants
21 and beneficiaries who filled a prescrip-
22 tion for a drug in that category or
23 class;

24 “(III) if applicable to that cat-
25 egory or class, a description of the

1 formulary tiers and utilization mecha-
2 nisms (such as prior authorization or
3 step therapy) employed for drugs in
4 that category or class;

5 “(IV) the total out-of-pocket
6 spending by participants and bene-
7 ficiaries, including participant and
8 beneficiary spending through copay-
9 ments, coinsurance, and deductibles;
10 and

11 “(V) for each drug—

12 “(aa) the amount received,
13 or expected to be received, from
14 any entity in rebates, fees, alter-
15 native discounts, or other remu-
16 neration—

17 “(AA) for claims in-
18 curred during the reporting
19 period; or

20 “(BB) that is related to
21 utilization of drugs or drug
22 spending;

23 “(bb) the total net spending,
24 after deducting rebates, price
25 concessions, alternative discounts

1 or other remuneration from drug
2 manufacturers, by the health
3 plan or health insurance coverage
4 on that category or class of
5 drugs; and

6 “(cc) the average net spend-
7 ing per 30-day supply and per
8 90-day supply, incurred by the
9 health plan or health insurance
10 coverage and its participants and
11 beneficiaries, among all drugs
12 within the therapeutic class for
13 which a claim was filed during
14 the reporting period.

15 “(2) PRIVACY REQUIREMENTS.—Health insur-
16 ance issuers offering group health insurance cov-
17 erage and entities providing pharmacy benefits man-
18 agement services on behalf of a group health plan
19 shall provide information under paragraph (1) in a
20 manner consistent with the privacy, security, and
21 breach notification regulations promulgated under
22 section 264(c) of the Health Insurance Portability
23 and Accountability Act of 1996, and shall restrict
24 the use and disclosure of such information according
25 to such privacy regulations.

1 “(3) DISCLOSURE AND REDISCLOSURE.—

2 “(A) LIMITATION TO BUSINESS ASSOCI-
3 ATES.—A group health plan receiving a report
4 under paragraph (1) may disclose such informa-
5 tion only to business associates of such plan as
6 defined in section 160.103 of title 45, Code of
7 Federal Regulations (or successor regulations).

8 “(B) CLARIFICATION REGARDING PUBLIC
9 DISCLOSURE OF INFORMATION.—Nothing in
10 this section prevents a health insurance issuer
11 offering group health insurance coverage or an
12 entity providing pharmacy benefits management
13 services on behalf of a group health plan from
14 placing reasonable restrictions on the public dis-
15 closure of the information contained in a report
16 described in paragraph (1), except that such
17 issuer or entity may not restrict disclosure of
18 such report to the Department of Health and
19 Human Services, the Department of Labor, the
20 Department of the Treasury, the Comptroller
21 General of the United States, or applicable
22 State agencies.

23 “(C) LIMITED FORM OF REPORT.—The
24 Secretary shall define through rulemaking a
25 limited form of the report under paragraph (1)

1 required of plan administrators who are drug
2 manufacturers, drug wholesalers, or other direct
3 participants in the drug supply chain, in order
4 to prevent anti-competitive behavior.

5 “(4) REPORT TO GAO.—A health insurance
6 issuer offering group health insurance coverage or
7 an entity providing pharmacy benefits management
8 services on behalf of a group health plan shall sub-
9 mit to the Comptroller General of the United States
10 each of the first 4 reports submitted to a plan ad-
11 ministrator under paragraph (1) with respect to
12 such coverage or plan, and other such reports as re-
13 quested, in accordance with the privacy requirements
14 under paragraph (2), the disclosure and redisclosure
15 standards under paragraph (3), the standards speci-
16 fied pursuant to paragraph (5).

17 “(5) STANDARD FORMAT.—Not later than 6
18 months after the date of enactment of this section,
19 the Secretary shall specify through rulemaking
20 standards for health insurance issuers and entities
21 required to submit reports under paragraph (4) to
22 submit such reports in a standard format.

23 “(c) ENFORCEMENT.—

24 “(1) FAILURE TO PROVIDE TIMELY INFORMA-
25 TION.—An entity providing pharmacy benefits man-

1 agement services that violates subsection (a) or fails
2 to provide information required under subsection (b)
3 shall be subject to a civil monetary penalty in the
4 amount of \$10,000 for each day during which such
5 violation continues or such information is not dis-
6 closed or reported.

7 “(2) FALSE INFORMATION.—An entity pro-
8 viding pharmacy benefits management services that
9 knowingly provides false information under this sec-
10 tion shall be subject to a civil money penalty in an
11 amount not to exceed \$100,000 for each item of
12 false information. Such civil money penalty shall be
13 in addition to other penalties as may be prescribed
14 by law.

15 “(3) PROCEDURE.—The provisions of section
16 1128A of the Social Security Act, other than sub-
17 section (a) and (b) and the first sentence of sub-
18 section (c)(1) of such section shall apply to civil
19 monetary penalties under this subsection in the
20 same manner as such provisions apply to a penalty
21 or proceeding under section 1128A of the Social Se-
22 curity Act.

23 “(4) WAIVERS.—The Secretary may waive pen-
24 alties under paragraph (2), or extend the period of
25 time for compliance with a requirement of this sec-

1 tion, for an entity in violation of this section that
2 has made a good-faith effort to comply with this sec-
3 tion.

4 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
5 tion shall be construed to permit a health insurance issuer,
6 group health plan, or other entity to restrict disclosure to,
7 or otherwise limit the access of, the Department of Health
8 and Human Services to a report described in subsection
9 (b)(1) or information related to compliance with sub-
10 section (a) by such issuer, plan, or entity.

11 “(e) DEFINITIONS.—In this section:

12 “(1) LARGE EMPLOYER.—The term ‘large em-
13 ployer’ means, in connection with a group health
14 plan with respect to a calendar year and a plan year,
15 an employer who employed an average of at least 50
16 employees on business days during the preceding
17 calendar year and who employs at least 1 employee
18 on the first day of the plan year.

19 “(2) WHOLESALE ACQUISITION COST.—The
20 term ‘wholesale acquisition cost’ has the meaning
21 given such term in section 1847A(c)(6)(B) of the
22 Social Security Act.”.

23 (c) IRC.—

1 administrator (as defined in section 3(16)(A) of the Em-
2 ployee Retirement Income Security Act of 1974) of
3 such plan a report in accordance with this sub-
4 section, and make such report available to the plan
5 administrator in a machine-readable format (or as
6 may be determined by the Secretary, other formats).
7 Each such report shall include, with respect to the
8 applicable group health plan—

9 “(A) information collected from a patient
10 or copay assistance program administrator by
11 such entity on the total amount of copayment
12 assistance dollars paid, or copayment cards ap-
13 plied, or other discounts that were funded by
14 the drug manufacturer with respect to the par-
15 ticipants and beneficiaries in such plan;

16 “(B) total gross spending on prescription
17 drugs by the plan during the reporting period;

18 “(C) total amount received, or expected to
19 be received, by the plan from any entities, in re-
20 bates, fees, alternative discounts, and all other
21 remuneration received from the entity or any
22 third party (including group purchasing organi-
23 zations) other than the plan administrator, re-
24 lated to utilization of drug or drug spending
25 under such plan during the reporting period;

1 “(D) the total net spending on prescription
2 drugs by the plan during such reporting period;

3 “(E) amounts paid, directly or indirectly,
4 in rebates, fees, or any other type of compensa-
5 tion (as defined in section
6 408(b)(2)(B)(ii)(dd)(AA) of the Employee Re-
7 tirement Income Security Act of 1974) to bro-
8 kerage houses, brokers, consultants, advisors, or
9 any other individual or firm for the referral of
10 the group health plan’s business to the phar-
11 macy benefits manager, identified by the recipi-
12 ent of such amounts;

13 “(F)(i) an explanation of any benefit de-
14 sign parameters that encourage or require par-
15 ticipants and beneficiaries in the plan to fill
16 prescriptions at mail order, specialty, or retail
17 pharmacies that are affiliated with or under
18 common ownership with the entity providing
19 pharmacy benefit management services under
20 such plan, including mandatory mail and spe-
21 cialty home delivery programs, retail and mail
22 auto-refill programs, and cost-sharing assist-
23 ance incentives funded by an entity providing
24 pharmacy benefit management services;

1 “(ii) the percentage of total prescrip-
2 tions charged to the plan, or participants
3 and beneficiaries in such plan, that were
4 dispensed by mail order, specialty, or retail
5 pharmacies that are affiliated with or
6 under common ownership with the entity
7 providing pharmacy benefit management
8 services; and

9 “(iii) a list of all drugs dispensed by
10 such affiliated pharmacy or pharmacy
11 under common ownership and charged to
12 the plan, or participants and beneficiaries
13 of the plan, during the applicable period,
14 and, with respect to each drug—

15 “(I)(aa) the amount charged, per
16 dosage unit, per 30-day supply, and
17 per 90-day supply, with respect to
18 participants and beneficiaries in the
19 plan, to the plan; and

20 “(bb) the amount charged,
21 per dosage unit, per 30-day sup-
22 ply, and per 90-day supply, to
23 participants and beneficiaries;

24 “(II) the median amount charged
25 to the plan, per dosage unit, per 30-

1 day supply, and per 90-day supply, in-
2 cluding amounts paid by the partici-
3 pants and beneficiaries, when the
4 same drug is dispensed by other phar-
5 macies that are not affiliated with or
6 under common ownership with the en-
7 tity and that are included in the phar-
8 macy network of such plan;

9 “(III) the interquartile range of
10 the costs, per dosage unit, per 30-day
11 supply, and per 90-day supply, includ-
12 ing amounts paid by the participants
13 and beneficiaries, when the same drug
14 is dispensed by other pharmacies that
15 are not affiliated with or under com-
16 mon ownership with the entity and
17 that are included in the pharmacy
18 network of that plan;

19 “(IV) the lowest cost, per dosage
20 unit, per 30-day supply, and per 90-
21 day supply, for such drug, including
22 amounts charged to the plan and par-
23 ticipants and beneficiaries, that is
24 available from any pharmacy included
25 in the network of the plan;

1 “(V) the net acquisition cost per
2 dosage unit, per 30-day supply, and
3 per 90-day supply, if the drug is sub-
4 ject to a maximum price discount; and

5 “(VI) other information with re-
6 spect to the cost of the drug, as deter-
7 mined by the Secretary, such as aver-
8 age sales price, wholesale acquisition
9 cost, and national average drug acqui-
10 sition cost per dosage unit or per 30-
11 day supply, and per-90 day supply,
12 for such drug, including amounts
13 charged to the plan and participants
14 and beneficiaries among all phar-
15 macies included in the network of
16 such plan; and

17 “(G) in the case of a large employer—

18 “(i) a list of each drug covered by
19 such plan or entity providing pharmacy
20 benefits management services for which a
21 claim was filed during the reporting period,
22 including, with respect to each such drug
23 during the reporting period—

1 “(I) the brand name, generic or
2 non-proprietary name, and the Na-
3 tional Drug Code;

4 “(II)(aa) the number of partici-
5 pants and beneficiaries for whom a
6 claim for such drug was filed during
7 the reporting period, the total number
8 of prescription claims for such drug
9 (including original prescriptions and
10 refills), and the total number of dos-
11 age units and total days supply of
12 such drug for which a claim was filed
13 during the reporting period; and

14 “(bb) with respect to each
15 claim or dosage unit described in
16 item (aa), the type of dispensing
17 channel used, such as retail, mail
18 order, or specialty pharmacy;

19 “(III) the wholesale acquisition
20 cost, listed as cost per days supply
21 and cost per dosage unit on date of
22 dispensing;

23 “(IV) the total out-of-pocket
24 spending by participants and bene-
25 ficiaries on such drug after applica-

1 tion of any benefits under such plan,
2 including participant and beneficiary
3 spending through copayments, coin-
4 surance, and deductibles (but not in-
5 cluding any amounts spent by partici-
6 pants and beneficiaries on drugs not
7 covered under such plan, or for which
8 no claim was submitted to such plan);
9 “(V) for any drug for which
10 gross spending of the plan exceeded
11 \$10,000 during the reporting period—
12 “(aa) a list of all other
13 drugs in the same therapeutic
14 category or class, including brand
15 name drugs, biological products,
16 generic drugs, or biosimilar bio-
17 logical products that are in the
18 same therapeutic category or
19 class as such drug; and
20 “(bb) the rationale for pre-
21 ferred formulary placement of
22 such drug in that therapeutic
23 category or class, if applicable;
24 and

1 “(ii) a list of each therapeutic cat-
2 egory or class of drugs for which a claim
3 was filed under the plan during the report-
4 ing period, and, with respect to each such
5 therapeutic category or class of drugs dur-
6 ing the reporting period—

7 “(I) total gross spending by the
8 plan;

9 “(II) the number of participants
10 and beneficiaries who filled a prescrip-
11 tion for a drug in that category or
12 class;

13 “(III) if applicable to that cat-
14 egory or class, a description of the
15 formulary tiers and utilization mecha-
16 nisms (such as prior authorization or
17 step therapy) employed for drugs in
18 that category or class;

19 “(IV) the total out-of-pocket
20 spending by participants and bene-
21 ficiaries, including participant and
22 beneficiary spending through copay-
23 ments, coinsurance, and deductibles;
24 and

25 “(V) for each drug—

1 “(aa) the amount received,
2 or expected to be received, from
3 any entity in rebates, fees, alter-
4 native discounts, or other remu-
5 nation—

6 “(AA) for claims in-
7 curred during the reporting
8 period; or

9 “(BB) that is related to
10 utilization of drugs or drug
11 spending;

12 “(bb) the total net spending,
13 after deducting rebates, price
14 concessions, alternative discounts
15 or other remuneration from drug
16 manufacturers, by the plan on
17 that category or class of drugs;
18 and

19 “(cc) the average net spend-
20 ing per 30-day supply and per
21 90-day supply, incurred by the
22 plan and its participants and
23 beneficiaries, among all drugs
24 within the therapeutic class for

1 which a claim was filed during
2 the reporting period.

3 “(2) PRIVACY REQUIREMENTS.—Entities pro-
4 viding pharmacy benefits management services on
5 behalf of a group health plan shall provide informa-
6 tion under paragraph (1) in a manner consistent
7 with the privacy, security, and breach notification
8 regulations promulgated under section 264(c) of the
9 Health Insurance Portability and Accountability Act
10 of 1996, and shall restrict the use and disclosure of
11 such information according to such privacy regula-
12 tions.

13 “(3) DISCLOSURE AND REDISCLOSURE.—

14 “(A) LIMITATION TO BUSINESS ASSOCI-
15 ATES.—A group health plan receiving a report
16 under paragraph (1) may disclose such informa-
17 tion only to business associates of such plan as
18 defined in section 160.103 of title 45, Code of
19 Federal Regulations (or successor regulations).

20 “(B) CLARIFICATION REGARDING PUBLIC
21 DISCLOSURE OF INFORMATION.—Nothing in
22 this section prevents an entity providing phar-
23 macy benefits management services on behalf of
24 a group health plan from placing reasonable re-
25 strictions on the public disclosure of the infor-

1 mation contained in a report described in para-
2 graph (1), except that such entity may not re-
3 strict disclosure of such report to the Depart-
4 ment of Health and Human Services, the De-
5 partment of Labor, the Department of the
6 Treasury, the Comptroller General of the
7 United States, or applicable State agencies.

8 “(C) LIMITED FORM OF REPORT.—The
9 Secretary shall define through rulemaking a
10 limited form of the report under paragraph (1)
11 required of plan administrators who are drug
12 manufacturers, drug wholesalers, or other direct
13 participants in the drug supply chain, in order
14 to prevent anti-competitive behavior.

15 “(4) REPORT TO GAO.—An entity providing
16 pharmacy benefits management services on behalf of
17 a group health plan shall submit to the Comptroller
18 General of the United States each of the first 4 re-
19 ports submitted to a plan administrator under para-
20 graph (1) with respect to such plan, and other such
21 reports as requested, in accordance with the privacy
22 requirements under paragraph (2), the disclosure
23 and redisclosure standards under paragraph (3), the
24 standards specified pursuant to paragraph (5).

1 “(5) STANDARD FORMAT.—Not later than 6
2 months after the date of enactment of this section,
3 the Secretary shall specify through rulemaking
4 standards for entities required to submit reports
5 under paragraph (4) to submit such reports in a
6 standard format.

7 “(c) ENFORCEMENT.—

8 “(1) FAILURE TO PROVIDE TIMELY INFORMA-
9 TION.—An entity providing pharmacy benefits man-
10 agement services that violates subsection (a) or fails
11 to provide information required under subsection (b)
12 shall be subject to a civil monetary penalty in the
13 amount of \$10,000 for each day during which such
14 violation continues or such information is not dis-
15 closed or reported.

16 “(2) FALSE INFORMATION.—An entity pro-
17 viding pharmacy benefits management services that
18 knowingly provides false information under this sec-
19 tion shall be subject to a civil money penalty in an
20 amount not to exceed \$100,000 for each item of
21 false information. Such civil money penalty shall be
22 in addition to other penalties as may be prescribed
23 by law.

24 “(3) PROCEDURE.—The provisions of section
25 1128A of the Social Security Act, other than sub-

1 section (a) and (b) and the first sentence of sub-
2 section (c)(1) of such section shall apply to civil
3 monetary penalties under this subsection in the
4 same manner as such provisions apply to a penalty
5 or proceeding under section 1128A of the Social Se-
6 curity Act.

7 “(4) WAIVERS.—The Secretary may waive pen-
8 alties under paragraph (2), or extend the period of
9 time for compliance with a requirement of this sec-
10 tion, for an entity in violation of this section that
11 has made a good-faith effort to comply with this sec-
12 tion.

13 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
14 tion shall be construed to permit a group health plan, or
15 other entity to restrict disclosure to, or otherwise limit the
16 access of, the Department of the Treasury to a report de-
17 scribed in subsection (b)(1) or information related to com-
18 pliance with subsection (a) by such plan or entity.

19 “(e) DEFINITIONS.—In this section:

20 “(1) LARGE EMPLOYER.—The term ‘large em-
21 ployer’ means, in connection with a group health
22 plan with respect to a calendar year and a plan year,
23 an employer who employed an average of at least 50
24 employees on business days during the preceding

1 calendar year and who employs at least 1 employee
2 on the first day of the plan year.

3 “(2) WHOLESALE ACQUISITION COST.—The
4 term ‘wholesale acquisition cost’ has the meaning
5 given such term in section 1847A(c)(6)(B) of the
6 Social Security Act.”.

7 (2) CLERICAL AMENDMENT.—The table of sec-
8 tions for subchapter B of chapter 100 of the Inter-
9 nal Revenue Code of 1986 is amended by adding at
10 the end the following new item:

“Sec. 9826. Oversight of pharmacy benefits manager services.”.

11 **SEC. 4. INFORMATION ON PRESCRIPTION DRUGS.**

12 (a) IN GENERAL.—Subpart B of part 7 of subtitle
13 B of title I of the Employee Retirement Income Security
14 Act of 1974 (29 U.S.C. 1185 et seq.), as amended by sec-
15 tion 3, is further amended by adding at the end the fol-
16 lowing new section:

17 **“SEC. 727. INFORMATION ON PRESCRIPTION DRUGS.**

18 “(a) IN GENERAL.—A group health plan or a health
19 insurance issuer offering group health insurance coverage
20 shall—

21 “(1) not restrict, directly or indirectly, any
22 pharmacy that dispenses a prescription drug to a
23 participant or beneficiary in the plan or coverage
24 from informing (or penalize such pharmacy for in-
25 forming) a participant or beneficiary of any differen-

1 tial between the participant’s or beneficiary’s out-of-
2 pocket cost under the plan or coverage with respect
3 to acquisition of the drug and the amount an indi-
4 vidual would pay for acquisition of the drug without
5 using any health plan or health insurance coverage;
6 and

7 “(2) ensure that any entity that provides phar-
8 macy benefits management services under a contract
9 with any such health plan or health insurance cov-
10 erage does not, with respect to such plan or cov-
11 erage, restrict, directly or indirectly, a pharmacy
12 that dispenses a prescription drug from informing
13 (or penalize such pharmacy for informing) a partici-
14 pant or beneficiary of any differential between the
15 participant’s or beneficiary’s out-of-pocket cost
16 under the plan or coverage with respect to acquisi-
17 tion of the drug and the amount an individual would
18 pay for acquisition of the drug without using any
19 health plan or health insurance coverage.

20 “(b) DEFINITION.—For purposes of this section, the
21 term ‘out-of-pocket cost’, with respect to acquisition of a
22 drug, means the amount to be paid by the participant or
23 beneficiary under the plan or coverage, including any cost-
24 sharing (including any deductible, copayment, or coinsur-

1 ance) and, as determined by the Secretary, any other ex-
2 penditure.”.

3 (b) CLERICAL AMENDMENT.—The table of contents
4 in section 1 of the Employee Retirement Income Security
5 Act of 1974 (29 U.S.C. 1001 et seq.), as amended by sec-
6 tion 3, is further amended by inserting after the item re-
7 lating to section 726 the following new item:

“Sec. 727. Information on prescription drugs.”.

8 **SEC. 5. ADVISORY COMMITTEE ON THE ACCESSIBILITY OF**
9 **CERTAIN INFORMATION.**

10 (a) IN GENERAL.—Not later than January 1, 2025,
11 the Secretary of Labor (in this section referred to as the
12 “Secretary”) shall convene an Advisory Committee (in this
13 section referred to as the “Committee”) consisting of 9
14 members to advise the Secretary on how to improve the
15 accessibility and usability of information made available
16 in accordance the amendments made by section 3 and by
17 section 204 of division BB of the Consolidated Appropria-
18 tion Act, 2021 (Public Law 116–260), streamline the re-
19 porting of such information, and ensure that such infor-
20 mation fully meets the needs of employers, patients, re-
21 searchers, regulators, and purchasers.

22 (b) MEMBERSHIP.—The Secretary shall appoint
23 members representing end-users of the information de-
24 scribed in subsection (a). Vacancies on the Committee

1 shall be filled by appointment consistent with this sub-
2 section not later than 3 months after the vacancy arises.

3 (c) TERMINATION.—The Committee established
4 under this section shall terminate on January 1, 2028.

